



# HCFA FACT SHEET

April 2000

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## FIGHTING FRAUD, WASTE, AND ABUSE IN MEDICARE AND MEDICAID

*Overview: Since 1993, the Clinton Administration has fought against fraud, waste and abuse in the Medicare and Medicaid programs. The result is a record series of investigations, indictments and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly \$500 million as a result of health-care prosecutions. Since 1996, aggressive enforcement has recovered nearly \$1.9 billion, while other efforts to prevent improper and wasteful spending have saved an estimated \$60 billion.*

*In 1995, Health and Human Services Secretary Donna E. Shalala launched Operation Restore Trust, a ground-breaking and ongoing anti-fraud project aimed at coordinating federal, state, local and private resources in targeted areas. In his fiscal year 2001 budget proposal, President Clinton also unveiled a new investment of more than \$40 million to ensure a swift and coordinated response to waste, fraud and abuse involving the private insurance companies, which, by law, process and pay claims on behalf of Medicare.*

*Most doctors, hospitals and other health-care providers are honest and only want to be paid fairly for the essential services that they provide to the nearly 40 million Medicare beneficiaries. HCFA continues to work to ensure that providers are paid appropriately while it protects beneficiaries and taxpayers from improper payments caused by both honest errors and unscrupulous activity.*

**Operation Restore Trust.** In May 1995, Secretary Shalala launched Operation Restore Trust (ORT), a comprehensive anti-fraud initiative in five key states designed to test the success of several innovations in fighting fraud and abuse in Medicare and Medicaid. During its first two years as a demonstration, ORT identified \$23 in overpayments for every \$1 spent looking at suspected trouble spots in Medicare. HCFA, the HHS Inspector General (OIG) and the Administration on Aging are working in partnership to apply the ORT model nationwide.

**Improving Health Care Industry Compliance.** The HHS Inspector General has issued compliance program guidance for hospitals, durable medical equipment suppliers, clinical laboratories, home health agencies, third-party billers, Medicare+Choice organizations, and other providers to ensure greater compliance with Medicare and Medicaid statutes, regulations, and program directives. The guidelines are part of the Inspector General's continuing efforts to work with health care providers to promote voluntary compliance with applicable statutes, regulations and requirements pertaining to federal health care programs.

**Guaranteed and Expanded Funding.** In August 1996, President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA), which for the first time created a stable source of funding for fraud control. This law dedicated money each year for program-integrity activities under the Medicare Integrity Program. For fiscal year 2001, HCFA will receive \$680 million for these activities, up from \$630 million in fiscal year 2000.

**Hiring Special Program Integrity Contractors.** Using specific contracting authority provided by HIPAA, HCFA in May 1999 chose 13 companies, including financial management and technology companies, as its first-ever contractors devoted to protecting the Medicare Trust Fund. These contractors, who have health-care expertise, are tackling key tasks, including audits, medical reviews, data analysis, site visits and provider education, to stop and prevent fraud, waste and abuse.

**Fraud and Abuse Hotline.** HHS has expanded the 1-800-HHS-TIPS hotline started in 1995 to encourage the reporting of fraud and abuse in the Medicare and Medicaid programs. Assistance is available in English and Spanish. In February 1999, the Administration joined with the AARP to launch an initiative called "Who Pays? You Pay" to educate Medicare beneficiaries about how to identify and prevent improper payments and fraud. Since the campaign kick-off, more than 450,000 callers have contacted the hotline.

**Expanded Provider Education Campaign:** Medicare last year expanded an innovative education campaign to help doctors and other health-care providers understand Medicare's billing procedures. The \$1.3 million campaign features interactive computer courses, available through the Internet, to allow providers to study specific topics and to ensure accurate claims. This effort is one part of Medicare's estimated \$52 million investment in educating providers about program requirements.

**Making Sure Private Insurers Pay Claims.** HCFA in 1999 hired a new national contractor to streamline efforts to ensure that Medicare does not pay health-care claims that are the responsibility of private insurance companies. The contract uses private-sector expertise to build on the roughly \$3 billion Medicare saves each year by ensuring that private insurance companies pay their share of beneficiaries' health-care bills. By consolidating these efforts into a single contract, Medicare expects to increase its savings while improving service to beneficiaries, providers and insurers.

**Rewards for Fraud and Abuse Information.** The Incentive Program for Fraud and Abuse Information, which was created under HIPAA, was implemented in July 1998. Under this program, Medicare beneficiaries and others who report fraud and abuse in the Medicare program can be paid rewards if their information leads directly to the recovery of Medicare money.

**Comprehensive Plan for Program Integrity.** In February 1999, HCFA released its first Comprehensive Plan to highlight the agency's overall strategy for reducing fraud and abuse. The plan defined five overall focus areas: making medical review and benefit integrity activities more effective, implementing the Medicare Integrity Program, strengthening payment safeguards for new benefits in the Balanced Budget Act of 1997, promoting provider integrity and developing millennium contingency plans. In addition, the plan targets vulnerabilities in five settings with known risks: inpatient hospital, congregate care, managed care, community mental health centers, and nursing homes.

**Tightening Standards for Home Health Care Providers.** In September 1997, HCFA imposed a four-month moratorium on enrollment of new home health care providers in the Medicare program while new regulations were developed to keep unscrupulous and unqualified providers from entering the program. The moratorium was lifted in January 1998. After implementing the new regulations, HCFA also doubled the number of home health audits and increased claims review by 25 percent. In October 2000, HCFA expects to implement a new BBA-required prospective payment system for home health services.

**New Requirements for Durable Medical Equipment Suppliers.** In 1998, HCFA proposed new regulations for suppliers of durable medical equipment, including wheelchairs, canes and other medical supplies, to ensure that beneficiaries would be served by legitimate businesses. HCFA also began conducting on-site inspections of medical equipment suppliers when they apply to participate and when they re-enroll, to assure the businesses serving beneficiaries are legitimate. HCFA in 1999 began a competitive-bidding demonstration in Polk County, Florida, that is saving beneficiaries and Medicare 17 percent on certain supplies while protecting quality and access. A second demonstration is planned for this year.

**Targeting Fraud in Community Mental Health Centers.** In September 1998, HCFA announced steps to ensure that Medicare beneficiaries with acute mental illness receive quality treatment in community mental health centers and that Medicare pays appropriately for those services. As part of a comprehensive action plan, HCFA began terminating centers that were unable to provide Medicare's legally required core services, and required others to come quickly into compliance and to repay money that had been paid inappropriately for non-covered services or ineligible beneficiaries. In 1999, HCFA charged one of its MIP contractors with conducting unannounced site visits for all CMHC applicants to ensure that they provide all the services required for Medicare enrollment.

**Correct Coding Initiative.** In 1994, HCFA began the Correct Coding Initiative by awarding a contract for the development of correct coding policy for all physician billing codes referred to as current procedural terminology (CPT) codes.

**Requiring Contractors to Report Fraud Complaints to OIG Immediately.** Many contractors who process and pay claims defer reporting cases of suspected fraud to the OIG when the dollar amounts are low. In December 1998, HCFA sent memoranda to all contractors requiring them to refer cases of suspected fraud to the OIG immediately, regardless of the amount of money involved.

**Measurable Results.** Passage of the Government Management Reform Act in 1994 requires an annual audit of all government programs according to private sector accounting principles. These annual audits have given HCFA a new tool to measure its progress in combating improper payments to Medicare providers. Audits are conducted by the HHS Inspector General with HCFA's full cooperation. Over the past three years, the Inspector General found that the Medicare improper payments have declined by more than 40 percent. Medicare's payment error rate declined from 14 percent for Fiscal Year 1996 to 7.97 percent for Fiscal Year 1999. HCFA is ahead of its Government Performance Review Act goal of 9 percent by 1999 and remains committed to its aggressive strategy to achieve a 5 percent error rate by 2002.

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